STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING CLUB	6038 W 25TH ST INDIANAPOLIS, IN 46224

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R000000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint(s) IN00141343 and IN00147728. IN00141343 -Substantiated. State residential deficiencies related to the allegation(s) are cited at R178. IN00147728 -Unsubstantiated due to lack of evidence. Survey Date: April 24, 2014 Facility Number: 001132 Provider Number: 001132 AIM Number: N/A Survey Team Lora Brettnacher, RN-TC Mary Weyls, RN Census Bed Type: Residential: 48 Total 48 Census Payor Type: Other: 48 Total: 48 Sample: 7	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These State findings are cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on April 28, 2014.			
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of one person, with current Cardiopulmonary Resuscitation (CPR)	R000117	1. The facility corrected this deficiency by re certifying staff members. 2. the potential affected all residents. therefore, now, we met the guidelines and	04/25/2014

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	and first aide certificates, were on site at all times. This deficient practice had the potential to affect 48 of 48 residents whom resided in the facility. Findings include: During an interview on 4/24/2014 at 1:30 P.M., Qualified Medication Aide (QMA) #1 indicated her CPR/First Aide Certification had expired in "2012." QMA #1 indicated she worked "a lot" without any other staff present and if someone needed first aide or CPR she would call 911. She indicated she would not start CPR if a resident needed it but would call 911. During an interview on 4/24/2014 at 1:40 P.M., the owner of the facility indicated QMA had worked alone and she was not aware her CPR/First Aide certificate had expired. At this time the owner was asked to provide documentation of current CPR/First Aide certification for any staff currently employed. During an interview on 4/24/2014 at 2:00 P.M., the owner indicated she was unable to provide documentation which indicated current CPR/First Aide certification for any of her staff. The owner indicated there were 37 residents who wanted CPR in the event it was		regs the facility can ensure a minimum of more than one person with cpr on site at all times. 3. the facility has put together a log book of all cpr certificates for all the employees. all copies, are maintained in this log. they are recorded and will be re cert when due. which now all employees are on the same schedule so re cert will be at the same time. any new employees will be added to said log book and recorded if needed. 4. the office manager will keep track of log book and all records. she will monitor the log every time a new employee is hired if cpr cert is needed. monitoring shall be ongoing.	

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	needed. An undated policy titled "Cardiopulmonary Resuscitation" identified as current by the owner of the facility on 4/24/2014 at 1:26 P.M., indicated, "RESPONSIBILITY: LICENSED NURSE AND ANY PERSON IN THE FACILITY WITH CPR EXPERTISE. PURPOSE: To ventilate and establish circulation on a resident with absence of respirations and pulse...."			
R000178	410 IAC 16.2-5-1.6(b) Physical Plant Standards - Deficiency (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas. Based on observation and interview the facility failed to provide adequate ventilation for 1 of 1 smoking rooms. Findings include: During observation on 4/24/14 at 10:50	R000178	1. the facility will correct the deficiency by repairing the vent to get rid of the loud noise so the residents will keep it on. also, we will repair the doors from the hallway so there is no gap in them as to let smoke into the hall. also we will price smoke eaters to see if that is a possibility with funding.	06/01/2014

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	a.m., a heavy smell of cigarette smoke was noted from the dining room down the hall past the nurses station. Double doors were noted a few doors down from the dining area. The doors were slightly ajar. Seven residents were in the room smoking. A heavy haze of smoke was noted in the room. A door to the outside was open. No other form of ventilation was observed. During interview of Resident #1 on 4/24/14 at 11:30 a.m., the resident indicated she spends most of her time in her room because of the smoke coming from the "smoking room". On 4/24/14 at 11:30 a.m. Resident #1's room was observed across the hall from the dining area. Two large oxygen concentrators were in the resident's room. During general observation with the maintenance person on 4/24/14 at 12 noon, several residents were observed in the "smoking room" smoking. The room was filled with a heavy haze of smoke. The maintenance person flipped a switch and a small vent in the ceiling of the room came on. A loud noise was noted while the vent was on. During interview of the maintenance person on 4/24/14 at 12 noon, the		2. the facility reviewed residents by randomly interviewing them to see who was maybe having an issue. we ask for advice from residents to see if they had different ways we could help. 3. the maint staff will fix the vent and doors we will price out smoke eaters we will listen to resident concerns we will have a resident lounge open for non smokers night staff will do better at cleaning the smoking lounge staff will monitor smell 4. all staff are encouraged to observe their surroundings for smell of cigarette smoke, haze or resident complaints. the entire staff will be inserviced to this info. monitoring will be ongoing. maint will add this task of maintaining vent to the monthly fire and smoke alarm checks. addendum.....the night staff will clean lounge every night. the housekeeping staff will maintain the lounge on a daily basis any and all staff members housed in the clubhouse are encouraged to report problems to the front office management so maint staff can be notified to fix any problems. hereto the frequency shall be day and night.	

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	maintenance person indicated the residents would not leave the vent on due to the noise. Resident 1's clinical record was reviewed on 4/24/14 at 1 p.m. A diagnosis was noted of, but not limited to, COPD (chronic obstructive pulmonary disease). The most recent physician signed update orders were noted, dated 3/26/14. An order for 2 liters of oxygen per nasal cannula PRN [whenever necessary] was noted. This State tag relates to Complaint IN00141343.			
R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the dishwasher maintained temperatures recommended by the manufacture's instructions to ensure safe sanitation of dishes, cookware, and silverware used to prepare and serve food to residents. This deficient practice had the potential to affect 48 of 48 residents who consumed	R000273	1. the facility corrected the deficiency by turning up the water heater to the dishwasher. also a log book was instituted by the dietary mangager 2. the practice affected all residents. The facility will ensure the water temp is high enough during each wash. 3. the changes put into place are the water heater was turned up a daily log book was instituted with	04/25/2014

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	food from the facility's kitchen. Findings include: During observation on 4/24/2014 at 9:00 A.M., with the Dietary Manager present, the thermometer on the facility's dishwasher indicated the was temperature was 82 degrees and the rinse cycle was 85. The Dietary Manager immediately ran the dish machine a second time and the thermometer indicated the wash temperature was 90 degrees and the rinse temperature was 90 degrees. During an observation on 4/24/2014 at 9:15 A.M., with the Maintenance Manager and the Dietary Manager present, the facility's dishwasher was observed during a wash cycle. The thermometer indicated wash temperatures of 90 degrees and rinse water temperatures of 90 degrees. During an observation on 4/24/2014 at 11:15 A.M., with the Maintenance Manager and the Dietary Manager present, the facility's dishwasher was observed during a wash cycle. The thermometer indicated wash temperatures of 83 degrees and rinse water temperatures of 98 degrees. The Maintenance Manager immediately ran the dish machine a second time and the		times to record temps for each meal time and wash. if the temp is less than needed the dietary super will be notified immediately by staff . if water temp does not come to needed temp, the dishes will be washed by other means or disposable products will be used. the log sheets will be completed daily at each wash time. the dietary staff was inserviced on this practice by the dietary super. precautions are taken everyday 4. the dietary super will monitor with the help of her staff. she will bring in the maint super if needed and or the rental company if the need goes farther than facility.	

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	thermometer indicated the wash temperature was 98 degrees and the rinse temperature was 104 degrees. During an interview on 4/24/2014 at 9:00 A.M., the Dietary Manger indicated the wash and rinse temperature should be "at least 110 degrees." The Dietary Manger indicated dishwasher water temperatures were not monitored daily but weekly when the machine was "delimed." During this interview documentation of the manufactures instructions for the dishwasher was requested. During an interview on 4/24/2014 at 9:15 A.M., the Maintenance Manger stated, "I am not sure how it operates." The Maintenance Manger indicated the temperature should be 110 and he would turn up the water heater. During an interview on 4/24/2014 at 10:00 A.M., the owner indicated the dishwasher machine was a rental and she did not have a copy of the manufactures instruction. She indicated she would call the company and request a copy. During an interview on 4/24/2014 at 11:15 A.M., the Maintenance Manger indicated he turned up the water heater around 9:30 A.M."			

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	Review of the manufactures instruction provided by the facility's owner on 4/24/2014 at 1:47 P.M., indicated, " ...Specification information ES-2000 SERIES SPECIFICATIONS...Temperatures Wash (minimum 120 degrees F (Fahrenheit)... Rinse (minimum) 120 degrees F... Incoming Water (minimum) 120 degrees F... Incoming Water (recommended) 140 degrees F...." Review of the dishwasher temperature logs for April 2014 indicated the following temperatures: April 1-112 degrees, April 4-118 degrees, April 6-111 degrees, April 7-112 degrees, April 10-110 degrees, April 12-112 degrees, April 14-111 degrees, April 15-112 degrees, April 17-118 degrees, April 19-113 degrees, and April 22-112 degrees.			
R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test			

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	result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview the facility failed to ensure tuberculin skin testing was performed on admission and/or at least yearly for 4 of 5 residents reviewed (Resident #'s 1, 2, 3, and 5). Findings include: 1. Resident #1's clinical record was reviewed on 4/24/14 at 12:24 p.m., indication an admission date of 7/18/14. Documentation to indicate a mantoux (tuberculin testing) was administered was lacking. 2. Resident #2's clinical record was reviewed on 4/24/14 at 1:00 p.m. Documentation of the most recent mantoux test was dated 5/21/11. 3. Resident #3's record was reviewed on 4/24/2014 at 1:15 P.M. The record indicated Resident #3's last	R000410	1. the facility will correct the deficiency by doing an audit of all charts to see where documentation is lacking. also the facility will meet with the medical director to see if there are copies available of the tb tests that were performed. the medical director knows they were done as her staff is who stapled results to history and physicals and put them in the chart themselves. we the facility and the med director believe these results were removed from all charts as an act of sabotage by a former employee. 2. the facility will audit all charts to see which residents are affected. the staff will look for lack of documentation. 3. the changes put into place will be an audit will be done of all charts a log of missing info will be made a log of dates recorded on current tb info will be mademissing info will try to be found from overflow files and med director filesif info not found, new tb tests will be administerednew dates and info	05/31/2014

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	annual mantoux was administered on 8/12/12. 4. Resident #5's record was reviewed on 4/24/2014 at 1:30 P.M. The record indicated Resident #5 was admitted on 1/14/2014. Resident #5 had a 1st step mantoux administered on 1/8/14 and on 1/10/2014 was read with a negative result. The record lacked documentation which indicated Resident #5 was administered a 2nd step mantoux. During interview of QMA #1 on 4/24/14 at 1:15 p.m., the QMA indicated there was not documentation which indicated: Resident #1 received a mantoux test, documentation which indicated Resident #2 had a mantoux administered since 5/21/11, documentation which indicated Resident 3 had been administered a mantoux since 8/12/12, or documentation which indicated Resident #5 was administered a 2nd step mantoux. The QMA indicated a former employee was responsible for the tuberculin testing and "apparently didn't keep up with it." During an interview on 4/24/2014 at 2:15 P.M., the owner of the facility was asked to provide the facility's policies regarding screening for tuberculosis. An undated policy titled "TUBERCULOSIS SCREENING" and identified as current		will all be recordedall dates will be put on a monthly schedule along with history and physicalsmonthly tb tests will be administered by the rn to maintain proper resultsyearly and two step method for new residents will be maintained in the logthis will all be logged by the office manager once audit done by nursing staffchest x rays will be included in the log as well4. this will be maintained by nursing staff as soon as new residents come in. the office manger will then record new dates as needed. monitoring will be ongoing monthly as due dates come upon us or new residents are admitted.	

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	by the facility's owner on 4/24/14 at 2:15 P.M., indicated, "RESPONSIBILITY: LICENSED NURSE-PURPOSE To determine whether or not the resident has active tuberculosis. POLICY It is the policy of this facility to obtain evidence of or do tuberculosis screening on all residents admitted to the facility. This will be accomplished by obtaining a physician's order for a tuberculin test or chest X-ray as appropriate. A report of a chest X-ray or tuberculin test completed not more than 90 days before the resident is admitted to the facility is acceptable as valid evidence of tuberculosis screening. The owner was unable to provide a policy which indicated annual screening for tuberculosis would be done for all residents and/or a policy which indicated for residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test as part of the facilities infection control practice to screen for tuberculosis.			